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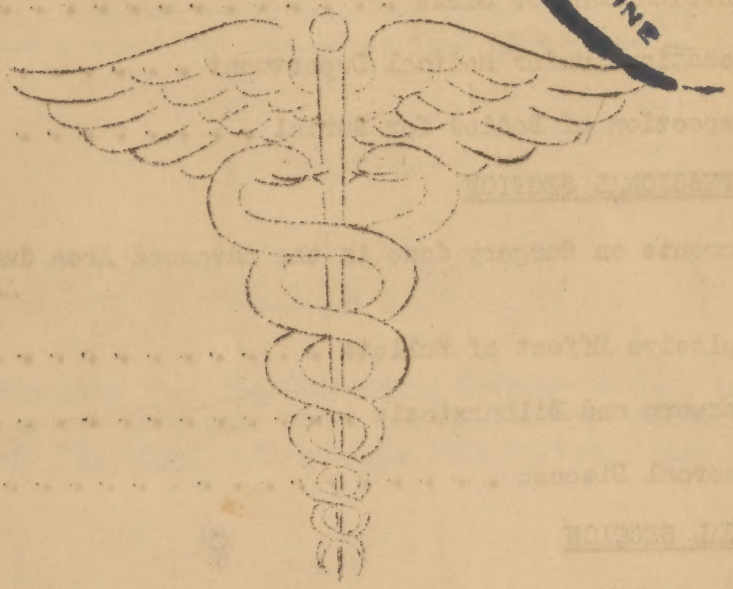

OFFICE OF THE SURGEON USASOS, SWPA

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F O R E W O R D

The Monthly Bulletin - Office of the Surgeon, U.S.A.S.O.S., S.W.P.A., is published for the purpose of disseminating information of general interest and of administrative value to the Medical Department personnel of the United States Army Forces in S.W.P.A.

All Medical Department officers and agencies are invited to submit items of general interest for future publication. It is not intended that the material herein contained shall have the force of directives (except where directives are quoted) but should be used as a guide by those concerned.

N O T E

The Surgeon requests that the Commanding Officer of each unit make such arrangements as are necessary to ensure that every commissioned officer and nurse in his organization reads this bulletin each month.

ADMINISTRATIVE SECTION

SPEED LIMITS

1. SPEED LIMITS. - Attention is invited to paragraph 19, AR 850-15, the following portions of which are particularly applicable to medical units:

> "19. Speed Limits. - a. The caution plate mounted on a motor vehicle indicates the maximum safe speed for which the vehicle is designed. This speed presumes good operating condition of vehicles, good road, load, normal traffic conditions, and skilled driving. It will not be exceeded.
>
> b. Fast driving over rough, slippery, or congested roads is prohibited and the fact that the vehicle was being operated within the authorized speed limit will not be accepted as an excuse for such driving.
>
> c. Speeds will not exceed the limits set by law or regulations of the States or town in which the vehicle is being operated."

2. A recheck on drivers' permits and the physical condition of drivers will be made to eliminate drivers holding permits who may be unfit to perform their duties.

CONTRIBUTIONS OR GIFTS

CONTRIBUTIONS OR GIFTS. - The War Department has directed that attention of all concerned be invited to the provisions of paragrahp 2e,(6) (a) and (b) AR 600-10, which is quoted as follows:

> "(a) No officer, clerk, or employee in the United States Government employ shall at any time solicit contributions from other officers, clerks, or employees in the Government service for a gift or present to those in superior official position; nor shall any such officials or clerical superiors receive any gift or present offered or presented to them as a contribution from persons in Government employ receiving a less salary than themselves; nor shall any officer or clerk make any donation as a gift or present to any official superior. Every person who violates this section shall be summarily discharged from the Government employ. (See R.S. 1784).
>
> (b) Receiving presents from persons not in the Military Establishment or in the employ of the Government in recognition of services rendered is not approved by the Department." GSXM 005.

PROMOTIONS UNDER MEDICAL DEPARTMENT T/O

PROMOTIONS UNDER MEDICAL DEPARTMENT T/O. - In accordance with letter GSC 320.3 Headquarters, USASOS, 14 November, 1942, Medical Department units that did not have specific authority to reorganize under new T/O's may recommend promotion of officers and promote enlisted men to fill vacancies existing under the old T/O. GSMD 210.2 x 220.2.

INSPECTION OF BODIES FOR BURIAL

INSPECTION OF BODIES FOR BURIAL. - The attention of the Base Section Surgeons and The Commanding Officers of all hospitals is called to W.D. Circular 165, 1941, Section 1, paragraph 5, and AR 40-590 Section 19, paragraph C (1), (2) and (3). These two regulations prescribe the methods of inspection that is required of bodies prepared for burial and apply to this area.

PROFESSIONAL SECTION

COMMENTS ON SURGERY DONE IN THE ADVANCED AREA DURING RECENT ACTION

Prepared by Lt. Col. W. B. Parsons, M.C.,
Surgical Consultant, Office of the Surgeon.

The greatest praise is due to the individuals and the units for the truly superior quality of the surgery that was performed in all units during the recent action in New Guinea. Cases arriving at the general hospitals on the mainland show conclusively that many lives were saved, that adequate shock therapy was available and had been used, and that in the vast majority of instances good judgment and technique had been exhibited. Quite naturally experience has indicated certain ways in which improvement can be effected, and the following comments are offered as constructive criticism.

The temptation to do too much must be resisted, but one must also be vigilant and careful to do enough. This thought was inspired by the occurrence of certain errors in judgment that are of particular importance where the man must be transported soon after operation. The fact of transportation is important in that movement, exposure, and exhaustion are inimical to smooth wound healing, because of obvious general reasons

and also because shifting of tissue planes from jolting causes hemorrhage and the formation of dead spaces which interferes with normal repair and predisposes to infection in an individual in poor condition. The following points seemed worthy of comment:-

a. Some wounds were sutured primarily, and almost all of these became seriously infected. Secondary, or delayed suture is feasible in many cases but again not when the man must be evacuated shortly or when bacterial control has not been made. Some successful ones were done where the man was kept in the same institution until wound healing had been completed.

b. Most unfortunately the word "packing" has been used extensively in the literature in describing the dressing of wounds after debridement. The word packing has been misconstrued by some to mean tight packing. This is bad enough in a wound adequately debrided but can be disastrous when little or no debridement has been done and the wounds of entrance and exit are tightly packed even with sulfonamide on vaseline gauze.

c. Perforating and penetrating wounds through large muscle bundles, with or without bone injury should be at least laid open with division of the overlying fascia to determine the presence or absence of massive muscle damage. It is in such cases that anaerobic infection is likely, and where removal of foreign bodies and dead tissue and the wide opening of the wound is so important. At Pearl Harbour it was shown that debridement as late as 72 hours after wounding could be done safely in those cases where sulfonamide had been applied thoroughly to the wound. Attention must be paid to the fact that we cannot rely exclusively on chemotherapy locally but must also give it P.O., in fact some claim that the oral route is the only important one, but that has not been proven.

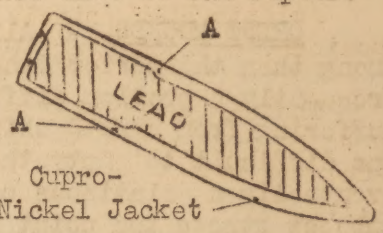
COMPOUND FRACTURES. - In this type of case the immediate need in the majority is treatment of shock, to prepare for operative attention to the wound with adequate exposure and whatever debridement is indicated. The production of a wide open wound following the removal of foreign bodies and small loose fragments of bone, with the careful leaving of all fragments attached to periosteum, will result in a large percentage of cases in the avoidance of anaerobic or severe purulent infection or osteomyelitis. Immobilization for transportation to insure against further trauma and shock is the third objective in treatment. Immobilization must be attained even though length and alignment may be imperfect. The cases will arrive at a general hospital in ample time for length and alignment to be taken care of if necessary. This of course should not be taken to mean that length and alignment are not important and that no effort should be made to have the bone or bones in as good position as possible, but merely thatthis particular feature is of secondary importance to shock therapy, proper care of the soft part wound and immobilization for transportation.

CHEST WOUNDS. - All types are of course interesting and important. Among them the perforating wound with considerable hemothorax was frequently a problem difficult to solve, a case for example being one not suffering from marked shift and twist of the vascular stalk but in whom it was difficult to empty the chest, where fluid re-accumulated, and where eventually a gelatinous coagulum formed. Practically all writers on this subject stress the point that clotting of pure blood does not occur for many days but that the presence of considerable blood in the pleural space causes an effusion in which fibrin is laid down or coagulation initiated which starts clotting in the contained blood. For this reason early aspiration is recommended even as early as twenty-four hours after wounding, and of course on any evidence of respiratory embarrassment. In order to keep the chest as empty as possible and thus to avoid the coagulum mentioned above, it is stated that repeated aspiration should be done perhaps as often as daily. Certainly by emptying the chest one can determine if fresh bleeding is occurring of sufficient volume to suggest an open intercostal or internal mammary vessel which would require surgical attack. Most writers suggest, or at least mention, early aspiration followed by the injection of air to maintain collapse until the lung wound has sealed over. In practically all cases there will be some pneumothorax present anyhow. It would hardly seem wise, until our experience is wider, to give air to all cases immediately following the first aspiration, but it should be kept in mind for use in those cases where oozing continues from the lung. Several writers suggest irrigation with saline to allow for liquefaction and aspiration of coagulated or partly clotted blood, to be followed by air injection. This would be a difficult technique to use in advanced units but might be occasionally applicable at a general hospital. In any event a certain number of cases at general hospitals will require intercostal thoracotomy with evacuation of clots and closure, and a number of cases of empyema will be unavoidable. On the whole conservative treatment gives the best results when based on an appreciation of the mechanics and physiology of respiration. Chemotherapy has been an invaluable aid. An excellent review of the literature by De Bakey appeared in the March 1942 International Abstract of Surgery under the title "Management of Chest Wounds".

EXPLOSIVE EFFECT OF BULLETS.

Many bullet wounds are being described as having been caused by "explosive" bullets. One should differentiate between true explosiveness, as is the case with an H.E. shell, and what is called explosive effect. The latter is due to fragmentation of a bullet which may occur when any bullet strikes a hard material in the right way, is not deflected but breaks up into pieces. The Japanese are not using true explosive bullets in their small arms such as the 25 cal. but the bullet as is shown in the

diagram is butt heavy and the jacket is so designed that it can rupture easily with discharge of the lead contents. A number of empty jackets have been removed which has made the observer think that the bullet was truly explosive. There is no question but that this type of bullet is associated with definite explosive effect, the line of rupture is indicated at A in the diagram. Bullets fired into wood do not seem to fragment as readily as those fired into water or sand. In battle casualties fragmentation is confined to those cases where a bone has been hit. The balance of the bullet perhaps explains why so many cases showed deviation of the bullet caused by resistant layers such as aponeurosis and the subcutaneous tissue.



HOOKWORM AND BILHARZIASIS

The attention of medical officers in S.W.P.A. is called to two diseases which have recently been reported to this office, Hookworm and Bilharziasis. Both of these conditions may be diagnosed from examination of the stools but as stool examinations often may not be employed routinely a brief clinical description of these two diseases is furnished which, upon being found in a patient, should lead to laboratory confirmation.

Hookworm (Ankylostomiasis) usually has an insidious and vague type of onset. It is chiefly characterized by a hypochromic normocytic anemia, cardiac palpitation, epigastric tenderness, and mental and physical exhaustion. In 80 - 90% of the cases there is a history of dermatitis of the toes or feet which causes intense itching and secondary infection because of scratching. This is due to larvae penetrating the cutaneous tissues.

An urticarial rash is sometimes observed during the development of the parasites in the body. Palpitation of the heart is early and marked, with shortness of breath on the slightest exertion. Epigastric tenderness is common and may simulate duodenal ulcer. Hookworm patients suffer from chronic fatigue mentally and physically.

The red cell count averages in marked cases 2,000,000 to 3,000,000 red cells per cu. m.m. The hemaglobin percentage in these cases is down to between 30 and 50. The color index is below one. The white count is usually normal. Eosinophilia is quite prominent and usually ranges from 15-35% of the leucocytes.

The clinical diagnosis may be confused with Beriberi, chronic nephritis, or malarial cachexia. The laboratory diagnosis can usually be made by finding hookworm ova in the feces generally by single microscopical examination without concentration.

Asiatic Bilharziasis (Schistosomiasis) is caused by the Schistosoma japonicum, a blood fluke whose intermediary host is a form of snail.

The early clinical manifestations of this disease are variable and may be characterized by urticaria, fever, pulmonary and abdominal symptons associated with a marked eosinophilic leucocytosis (10-20,000 cells per cu. m.m.).

Often local itchiness develops at the time the cercariae are invading the cutaneous tissues. Occasionally a transient dermatitis occurs which is a true cercarial dermatitis.

There is frequently a stage characterized by toxic or anaphylactoid features which occurs four to eight weeks after exposure. The most prominent developments are intense eosinophilia, generalized urticaria, transient edema and fever, cough, dyspnea, pain in epigastrium, nausea, or diarrhea. Examination may reveal a tender enlargement of the liver and spleen, rales and dullness of the lungs.

From the third month dysenteric like attacks may predominate. In this stage evidence of pulmonary fibrosis and involvement of the central nervous system may appear.

In the final stage, after many years, malnutrition, anemia, ascites, hepatomegaly and splenomegaly may occur.

The diagnosis in the early stage may be confused with bronchitis, tuberculosis, or typhoid fever. Later amebiasis may be suspected.

The diagnosis is best established in the early stages by a complement fixation reaction and intradermal skin tests. Later, the diagnosis of eggs in the stool will definitely establish the presence of the condition.

VENEREAL DISEASE

1. It will be noted that in AR 40-210 par 24 C (2) it states - "when the patient has received the amount of treatment outlined by the recommendations of the Surgeon General, active treatment will be discontinued, and an entry "treatment completed"(date) will be made conspicuously on page 1 of the register". In par 24 C (4) it states - "the register will be closed when the case is designated as "result satisfactory"." Although the new regulation does not specifically state that serological tests should be done at stated intervals after completion of treatment, it is the interpretation of this office, that medical officers should follow the recommendation of Circular Letter No. 74, S.G.O. dated 25 July, 1942, wherein it recommends serological tests 3 months and 6 months after completion of treatment before final closure and forwarding of the register.

2. Venereal Disease Posters have been recently mailed to The Commanding Officers of all units in the area in so far as it is possible. It is recommended that the Unit Surgeons see to it that the posters are displayed in the designated places; also that locations of prophylactic stations be attached to these posters.

3. It is very gratifying to note that the December Consolidated V. D. Statistics report for the S.W.P.A. showed that the rate was 18.6 per 1000 per year. This rate is the lowest point reached in the area, and it illustrates that constant effort on the part of all concerned can and will decrease the incidence of venereal diseases.

DENTAL SECTION

CONSERVATION OF DENTAL BURS AND HANDPIECES

The assortment of sizes of dental burs for the Army has recently been reduced and priority has been given for the manufacture of a limited number of certain sizes. Because of the probable difficulty in procuring sufficient quantities of dental burs to meet requirements, it will be necessary for all those concerned in the issue of dental burs, especially dental officers and assistants who use and care for them, to exercise the utmost diligence in the conservation of their consumption.

Great care will be exercised in the preservation of dental engine handpieces. Thorough cleaning and oiling will be made a daily routine practice in order to prolong their serviceability.

ARMY NURSE CORPS SECTION

NURSES PORTION OF HOSPITAL FUNDS.- With the change in status of members of the Army Nurse Corps, funds which had accumulated in the nurses portion of the various hospital funds prior to the change in status may be turned over to the nurses for pro rata refund to individuals or for such other distribution as may be desired and approved by the Commanding Officer. GSMD 123.1 x 221 Nurses.

No civilian clothes will be worn at any time by members of the Army Nurse Corps. For off duty hours in quarters and for sports, culottes

and slacks will be worn, except in the Advance Base where slacks and long sleeves will be worn from sundown to sunup. This amends the article on culottes and slacks in par. 2 of the July issue of the Bulletin.

Handkerchiefs will not be displayed in the pockets of nurses uniforms.

With the change of status the following is quoted for the benefit of all nurses: AR 40-20, Aug. 15, 1942 - par. 2b (4):

"In all reports, returns, orders and other official documents, the titles corresponding to the relative rank conferred upon nurses will be used in the same manner as is prescribed for commissioned officers".
